SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 11

----------X

JILLIAN FONSECA,

Plaintiff, INDEX NO. 805025/14

-against-

ADAM T. HERSHKIN, D.M.D., ADAM T. HERSHKIN, D.M.D., P.C., and ST. LUKE'S ROOSEVELT HOSPITAL CENTER,

Defendants.

----------X

JOAN A. MADDEN, J.:

In this action for damages for dental malpractice and lack of informed consent, defendant St. Luke's-Roosevelt Hospital Center ("St. Luke's" or "hospital") (motion seq. 004) and defendants Adam T. Hershkin, D.M.D. and Adam T. Hershkin, D.M.D., P.C. (collectively "Dr. Hershkin") (motion seq. 005) move for summary judgment. [1] Plaintiff opposes the motions in part.

On April 27, 2012, defendant Dr. Hershkin, an oral and maxillofacial surgeon, extracted two of plaintiff's wisdom teeth (teeth #16 and #32). Plaintiff, who was 24 years old at the time, subsequently developed an infection at the site of extraction of tooth #32. Plaintiff alleges defendants failed to properly diagnose and treat the infection, and as a result the infection spread to the bone, she developed osteomyelitis of the mandible, and by the time she was properly diagnosed and treated by a different surgeon at a different hospital, her jawbone was "ravaged by osteomyelitis," requiring multiple reconstructive surgeries. Based on the expert affidavit of

[1]Motion sequence numbers 004 and 005 are consolidated for determination herein.

plaintiff's oral and maxillofacial surgeon,[2] the alleged departures include the following: 1) Dr. Hershkin's failure to obtain a consultation with an infectious disease specialist during plaintiff's hospital admission from May 7 -10, 2012; 2) Dr. Hershkin's and non-party Dr. Wintston's discharging plaintiff from the hospital on May 10, 2012; 3) Dr. Hershkin's failure to preserve plaintiff's loose bone fragments during the irrigation, drainage and debridement procedure on May 23, 2012, so they could be sent to pathology to be evaluated for osteomyelitis; 4) Dr. Hershkin's failure to take a biopsy of the bone in the area where he found bone missing on May 23, 2012; 5) Dr. Hershkin's failure to obtain an infectious disease consultation after the May 23, 2012 procedure, and again after examining plaintiff on May 30, 2012 and June 12, 2012, when she exhibited signs of osteomyelitis, including impairment of the inferior alveolar nerve.[3]

The following facts are not disputed unless otherwise noted. On April 9, 2012, plaintiff first presented to Dr. Hershkin complaining of pain at tooth #32, the lower right wisdom tooth. Dr. Hershkin took a Panorex film and examined plaintiff. His impression was impacted wisdom teeth and he recommended extraction of teeth #16 and #32. On April 27, 2012, plaintiff signed a consent form, and Dr. Hershkin performed an oral surgical extraction of teeth #16 and #32.

---

[2]At oral argument, St. Luke's made an oral motion to declare plaintiff's out-of-state expert affidavits a nullity for lacking certificates of conformity as required by CPLR 2309(c). In response, plaintiff withdrew the affidavit of her infectious disease expert and was given 30 days to provide a certificate of conformity for the affidavit of her oral surgeon, which was submitted on May 24, 2018. The Court notes that the absence of a certificate of conformity is a "mere irregularity" that can be excused, corrected later and given nunc pro tunc effect. See Redlich v. Stone, 152 AD3d 432 (1st Dept 2017); American Casualty Co v. Motivated Security Services Inc, 148 AD3d 521 (1st Dept 2017); Gyamfi v. Citywide Mobile Response Corp, 146 AD3d 612 (1st Dept 2017); DaSilva v. KS Realty, LP, 138 AD3d 619 (1st Dept 2016).

[3]To the extent the bills of particulars allege additional departures that are not addressed by plaintiff's experts, the Court finds that plaintiff is no longer relying on those departures and any arguments relating to those departures will not be considered.

Plaintiff was discharged on Percocet and told to follow-up in one week. On May 1, 2012, plaintiff advised Dr. Hershkin that she was having pain at the site of the lower right extraction and Percocet was making her "sick." Dr. Hershkin prescribed Vicodin and gave her an appointment for the next day. When Dr. Hershkin examined plaintiff on May 2, 2012, he found mild swelling in the area of tooth #32, without pus, and a large amount of food debris. He irrigated the area and placed gel foam packing. He also prescribed penicillin and told plaintiff to follow-up if no improvement. On May 3, 2012, plaintiff sent Dr. Hershkin a text message that she felt much better.

Plaintiff returned to Dr. Hershkin on May 7, 2012, complaining of pain and swelling on swallowing, and advising that she had not filled the prescription for penicillin until the night before. Dr. Hershkin found that plaintiff's mouth had limited opening due to pain, mild painful swelling at the right floor of the mouth near tooth #32, and tenderness at the right inferior border of the mandible, which was still palpable with slight swelling. Dr. Hershkin sent plaintiff to St. Luke's for a CT scan and she was admitted for observation and intravenous administration of the antibiotic Clindamycin. On May 8, 2012, Dr. Hershkin incised and drained the area of tooth #32. On May 9, 2012, plaintiff had pain and swelling but no fever, and morphine was increased. On May 10, 2012, Dr. Hershkin examined plaintiff at 8:00 a.m, noted she was "slightly improving/not worsening" and ordered a repeat "CT scan re-evaluate in p.m." The radiologist's report compared the results of the May 10 CT scan with the prior scan taken on May 7. Plaintiff was discharged later in the day on May 10, 2012.

Dr. Hershkin examined plaintiff in his office the next day, May 11, 2012, and indicated she was feeling "much better." He noted that the pharyngeal swelling was 75% improved, the

facial swelling and erythema were 50% improved, and the sublingual and anterior ramus swelling was 25% improved. Dr. Hershkin next saw plaintiff on May 14, 2012, when she felt "better overall." He noted that the pain was localized to the right masseter and throat, and that she could open her jaw "slightly better but still limited." He also noted that she reported transient right lower lip numbness the day before, which was then resolved. He found the swelling had improved and there was no drainage. His impression was that she was "improving nicely" and his plan was to increase stretching exercises and follow-up in one week.

On May 16, 19 and 20, plaintiff sent Dr. Hershkin text messages complaining of pain in the location of the "tooth socket," and swelling in her neck and on her jaw line. Dr. Hershkin responded by asking about the location and amount of pain and swelling, and on May 20, he said he wanted to see her the "next morning." Plaintiff saw Dr. Hershkin on May 23, 2012 and he performed an incision and drainage of the right masticator space and debridement of the #32 surgical site. Dr. Hershkin noted "no purulence . . . Bone was found to be missing and/or loose on lingual plate. Loose bone was lost in suction." On May 24, plaintiff sent Dr. Hershkin a text message that she was having a "good day" and did not need any painkillers. Dr. Hershkin saw plaintiff on May 25 and noted that she "feels much better. No difficulty swallowing or breathing. Swelling decreased and pt. now reports 'tingling' in lip. . . . neck soft, no swelling . . . drain and sutures removed and wound irrigated."

Plaintiff missed her May 28 appointment and saw Dr. Hershkin on May 30, when he noted that she "feels better" regarding pain and swelling, but reported "intermittent shooting pain, total anesthesia and pins & needles right IAN [inferior alveolar nerve] distribution." On examination he found "all extraoral and intraoral areas of swelling significantly better. Socket

clean. No purulence." He also performed nerve testing which showed an absence of cold and sharp sensation, and diminished two point discrimination along the right lower jaw.

On June 1 and June 6, plaintiff sent Dr. Hershkin text messages that she was having "throbbing" pain. Plaintiff saw Dr. Hershkin on June 12, 2012 and reported no change in the numbness of the lower right jaw, and that she had been stretching and could open her jaw wider. Dr. Hershkin examined plaintiff, performed nerve testing, and noted his impression as "improving pain, swelling, ROM. IAN hypethesia unchanged," and that he discussed the option of a "neurosurgery consult."

On June 22, 2012, plaintiff spoke to Dr. Hershkin from San Francisco that after "feeling significant improvement since the last procedure, she woke up that morning with swelling and pain again." He recommended that she see someone in San Francisco, but she was returning home that day. Dr. Hershkin saw plaintiff on Sunday, June 24, 2012 and noted that she was feeling "a little better since starting Clindamycin yesterday AM." His examination showed swelling and tenderness in the mouth, and opening was limited. He explained to plaintiff and her father on the phone, that

> I am concerned because this post-op course has been very atypical for a young, healthy patient after a routine procedure. She is not responding to normal treatment and should have gotten better. I plan to review all films with a head and neck radiologist, to get a second opinion and possibly to consult with an infectious disease specialist. PT did not want to go to St. Luke's or Roosevelt and will got to NYU for CT scan today. . .Waiting to hear from patient.

That was the last time plaintiff saw Dr. Hershkin.

On June 24, 2012, plaintiff was admitted to New York University Medical Center where she was treated by Dr. David Hirsch, who diagnosed plaintiff as having osteomyelitis. Plaintiff

underwent two surgeries, including a partial resection of her jaw on June 27, 2012 and a fibula bone transplant to reconstruct her jaw, with implants on February 28, 2013.

Plaintiff commenced the instant action on January 21, 2014. The complaint asserts causes of action against St. Luke's and Dr. Hershkin for medical malpractice (first cause of action) and lack of informed consent (second cause of action), and a cause of action against St. Luke's for negligent granting or renewal of Dr. Hershkin's hospital privileges (third cause of action). St. Luke's and Dr. Hershkin are now moving for summary judgment dismissing the complaint in its entirety. Plaintiff opposes dismissal of only the medical malpractice claims against St. Luke's and Dr. Hershkin.

St. Luke's Summary Judgment Motion (004)

St. Luke's is moving for summary judgment dismissing the three causes of action asserted against it for medical malpractice, lack of informed consent and negligent granting or renewal of Dr. Hershkin's hospital privileges. Plaintiff's opposition addresses only the medical malpractice claim and is silent as to the other two causes of action.

In her medical malpractice claim against St. Luke's, plaintiff seeks to impose vicarious liability on St. Luke's for the alleged negligence of defendant Dr. Hershkin and the hospital's resident, non-party Dr. Winston, during her hospital admission from May 7 to May 10, 2012. Specifically, plaintiff alleges that during that time, Dr. Hershkin alone departed from the standard of care by failing to obtain a consultation with an infectious disease specialist, and that both Dr. Hershkin and Dr. Winston departed from the standard of care by discharging her on May 10, 2012.

It is well settled that a "hospital cannot ordinarily be held vicariously liable for the malpractice of a private attending physician who is not its employee unless a patient comes to the emergency room seeking treatment from the hospital and not from a particular physician of the patient's choosing, and there is created an apparent or ostensible agency by estoppel." Suits v. Wyckoff Heights Medical Center, 84 AD3d 487, 488 (1st Dept 2011). Moreover, "[a] hospital may not be held concurrently liable for injuries suffered by a patient who is under the care of a private attending physician chosen by the patient where the resident physician and nurses employed by the hospital merely carry out the orders of the private attending physician, unless the hospital staff commits 'independent acts of negligence or the attending physician's orders are contraindicated by normal practice.'" Id (quoting Cerny v. Williams, 32 AD3d 881 [2nd Dept 2006]).

At the outset, the court addresses plaintiff's objection that St. Luke's has failed to submit an expert affirmation or affidavit in support of its motion. Plaintiff cites no legal authority holding that the opinion of a medical expert is required to resolve the issue of whether a hospital can be held vicariously liable for the negligence of a patient's private attending physician or its own employee. To the contrary, in many cases, the issue is resolved based solely on deposition testimony and medical records. See e.g. Burnett-Joseph v. McGrath, 158 AD3d 526 (1st Dept 2018) (attending physician's deposition raised issue of fact as to whether resident exercised independent medical judgment on the amount and type of sedation to administer); Irizarry v. St. Barnabas Hospital, 145 AD3d 529 (1st Dept 2016) (testimony of hospital employees and hospital records established that residents were working under the attending physician's supervision, had no authority to discharge plaintiff and did not exercise any independent medical judgment in the

decision to discharge plaintiff); Cerny v. Williams, supra (hospital records and deposition testimony failed to show that resident was acting pursuant to attending physician's directions and that resident did not exercise any independent medical judgment in the decision to administer pitocin).

Here, the record conclusively establishes that Dr. Hershkin was not employed by St. Luke's and plaintiff was admitted to St. Luke's as his private patient. In opposition, plaintiff does not dispute that Dr. Hershkin was a private attending physician for which the hospital bears no liability. Since it is conceded that Dr. Hershkin was a private attending physician who was not in St. Luke's employ, St. Luke's cannot be held vicariously liable for any negligence on Dr. Hershkin's part during plaintiff's admission from May 7 to May 10, 2012 . See See Hill v. St. Clare's Hospital, 67 NY2d 72 (1986); McDonald v. Beth Israel Medical Center, 136 AD3d 516 (1st Dept 2016); Cerny v. Williams, supra. St. Luke's, therefore, is entitled to judgment as a matter of law dismissing the first cause of action to the extent plaintiff alleges St. Luke's is vicariously liable for the negligence of Dr. Hershkin.

Turning to non-party Dr. Winston, it is undisputed that in May 2012, he was employed by St. Luke's as Chief Resident of Oral and Maxillofacial Surgery. In seeking to hold St. Luke's vicariously liable for the alleged negligence of its employee, Dr. Winston, plaintiff alleges that he exercised independent medical judgment in the decision to discharge plaintiff. See Irizarry v. St. Barnabas Hospital, supra; McDonald v. Beth Israel Medical Center, supra; France v. Packy, 121 AD3d 836 (2nd Dept 2014); Cerny v. Williams, supra.

Based on the deposition testimony, plaintiff's medical records, and the text messages between plaintiff and Dr. Hershkin, St. Luke's has made a prima facie showing that Dr. Hershkin

made the decision to discharge plaintiff on May 10, 2012, and Dr. Winston did not exercise any independent medical judgment in that decision. Dr. Hershkin's progress notes from May 9, 2012, the day before plaintiff was discharged, show that his "plan" was "likely" to discharge plaintiff "tomorrow." His May 10, 2012 progress notes show that he examined plaintiff at 8:00 a.m. and his "plan" was for jaw physical therapy, "continue course," and "CT scan re-evaluate in p.m." The medical records show that plaintiff had a CT scan sometime before noon on May 10. Dr. Hershkin testified that he received the report of the CT scan, and spoke to the radiologist and Dr. Winston about the results. Although he could not remember the "exact words" of the conversation with the radiologist, he testified that he would have told the radiologist

> exactly what I did in the operating room two days before, and to find out if these changes are consistent with post-op changes from the drainage that I did, as opposed to the infection going in the wrong direction. And based upon the answer I would have gotten, the patient was discharged. Not that I asked the radiologist whether I could discharge the patient. I got the information that I needed in order to make my decision to let the patient go.

Dr. Hershkin acknowledged that he was not present when plaintiff was discharged, explaining that Dr. Winston "evaluated her at discharge" and prepared the discharge summary, which he and Dr. Winston both signed. Dr. Hershkin testified that he spoke to Dr. Winston "right around that time he discharged her . . . around 4:00, 4:20." When asked what he meant when he said Dr. Winston "discharged her," Dr. Hershkin explained that Dr. Winston "put the order in, which I told him to do," and answered "absolutely" when asked if the discharge was at "your behest." Dr. Hershkin testified that Dr. Winston

> told me what he saw when examining that patient, what the patient told him. And that would have gone towards my decision to discharge her or keep her in the hospital . . . I would have reviewed the chart after the last time I saw her. An then prior to discharge, the resident would have contacted me and given me whatever

> information I needed, both what he would know that I would need, and anything lacking, I would have asked. And I would have used that information to make my decision.

Dr. Winston likewise testified that he did not "recommend discharge" and it

> would be Dr. Hershkin collecting the data and making a decision. Our conversations would have been typically about facts of the exam and CT scan, and there would not have been a recommendation on my part. It would be Dr. Hershkin collecting the data and making a decision.

Plaintiff testified about the text messages she sent to and received from Dr. Hershkin on May 10, 2012, as to how she was feeling, the CT scan taken that day and whether she would be discharged that day. St. Luke's submits printed copies of those messages, which show that at 9:07 a.m, plaintiff wrote to Dr. Hershkin, "After getting up and eating, I am feeling much better." At 2:22 p.m., she wrote, "I had the scan an hour or so ago, I'm still felling pretty good." At 3:24 p.m., Dr. Hershkin responded, "Looks good. I'm sending dr. Winston to check you out and if all looks good you are going home today and I'll see you tomorrow early afternoon in my office. Call me tonight for an update please." Plaintiff also testified that May 10, was the "day I wanted to leave because I wasn't sleeping well in the hospital. So he [Dr. Hershkin] said I could leave after I get my scan to see how they look."

In view of the foregoing, St. Luke's has established prima facie that Dr. Hershkin made the decision to discharge plaintiff on May 10, 2012, and that Dr. Winston did not exercise any independent medical judgment in that decision. See Barrocales v. New York Methodist Hospital, 122 AD3d 648 (2nd Dept 2014). The burden shifts to plaintiff to raise a triable issue of fact.

In opposition, plaintiff asserts that on May 10, 2012, Dr. Winston exercised his own independent medical judgment when he evaluated plaintiff's condition in the absence of Dr. Hershkin's presence and determined that plaintiff should be discharged. Plaintiff's assertion is not supported by the record, as she fails to controvert both Dr. Hershkin's and Dr. Winston's clear and consistent testimony that Dr. Hershkin and *not* Dr. Winston, made the decision to discharge plaintiff on May 10, 2012.

Even though Dr. Hershkin was not physically present at the hospital when plaintiff was discharged, that fact alone is insufficient to show or suggest that Dr. Winston exercised his own independent medical judgment in the decision to discharge plaintiff. To the contrary, Dr. Hershkin's progress notes from May 9, 2012, show he was planning to discharge plaintiff the next day, and on May 10, 2012, he examined plaintiff in the morning, ordered a repeat CT scan for comparison with the prior one taken when plaintiff was admitted, and ordered plaintiff to be re-evaluated in the "p.m." Dr. Hershkin spoke to the radiologist about the results of the CT scan and spoke to Dr. Winston before plaintiff was discharged. Even though Dr. Winston evaluated plaintiff before she was discharged and prepared the discharge summary, Dr. Hershkin's prrogess notes show that the evaluation was performed at his explicit direction. Dr. Winston unequivocally testified that he simply presented the facts to Dr. Hershkin and Dr. Hershkin made the decision to discharge plaintiff. At best the record shows, as Dr. Hershkin testified, that Dr. Winston was "actively involved" in plaintiff's treatment and participated in her discharge, which fails to demonstrate the exercise of any independent medical judgment. See France v. Packy, supra; Soto v. Andaz, 8 AD3d 470 (2nd Dept 2004).

Thus, since plaintiff has failed to raise an issue of fact as to whether Dr. Winston exercised his own independent medical judgment in the decision to discharge plaintiff on May 10, 2012, St. Luke's is entitled to judgment as a matter of law dismissing the first cause of action to the extent it alleges vicariously liability for the negligence of Dr. Winston.

St. Luke's is also moving for summary judgment dismissing the second cause of action for lack of informed consent claim. As noted above, plaintiff does not oppose this branch the motion.

"In terms of a medical malpractice claim predicted on lack of informed consent, where a private physician attended his or her patient at the facilities of a hospital, it is the duty of the physician, not the hospital, to obtain the patient's informed consent." Salandy v. Bryk, 55 AD3d 147 (2nd Dept 2008); accord Bailey v. Owens, 17 AD3d 222 (1st Dept 2005). The hospital may only be liable if it knew or should have known that the private physician using its facilities was acting without informed consent, or it should have had reason to suspect malpractice. See Cirella v. Central General Hospital, 217 AD2d 680 (2nd Dept), lv app den 87 NY2d 801 (1995).

As determined above, Dr. Hershkin was plaintiff's private attending physician and was not an employee of St. Luke's. On May 8, 2012, when plaintiff was at St. Luke's, Dr. Hershkin performed an incision and drainage procedure. At her deposition, plaintiff acknowledged that prior to that procedure, she signed a Consent for Surgical Intervention and a Consent for Anesthesia, both dated May 8, 2012. Dr. Hershkin testified that he discussed the risks and benefits with plaintiff prior to the May 8, 2012 procedure. Plaintiff also testified that on May 10, 2012, she signed a Consent for Diagnostic Procedure and/or Treatment.

Under these circumstances, where it is undisputed that Dr. Hershkin was plaintiff's private physician and plaintiff signed the May 8, 2012 consent forms, and in the absence of evidence that St. Luke's knew or should have know that Dr. Hershkin was acting without informed consent, St. Luke's has made a prima facie showing that no basis exists for holding it liable for any alleged failure to obtain plaintiff's informed consent. See Salandy v. Bryk, supra; Bailey v. Owens, supra; Cirella v. Central General Hospital, supra. Thus, in the absence of opposition, St. Luke's is entitled to judgment as a matter of law dismissing the second cause of action for lack of informed consent claim insofar as it is asserted against St. Luke's.

Finally, St. Luke's is moving for summary judgment dismissing the third cause of action which essentially alleges that St. Luke's was negligent in granting or renewing Dr. Hershkin's hospital privileges. Again, as noted above, plaintiff has no opposition to this branch of the motion. A hospital has a duty to review a physician's qualifications before granting or renewing his or her staff privileges. See Napolitano v. Huss, 272 AD2d 308 (2nd Dept 2000); Sledziewski v. Cioffi, 137 AD2d 186 (3rd Dept 1988); Raschel v. Rish, 110 AD2d 1067 (4th Dept), app dism 65 NY2d 923 (1985). Based on Dr. Herskin's testimony regarding his educational background and experience, St. Luke's has made a sufficient prima facie showing as to his qualifications and credentials for staff privileges at St. Luke's. St. Luke's, therefore, is entitled to judgment as a matter of law dismissing the third cause of action in its entirety.

Dr. Hershkin's Summary Judgment Motion (005)

Dr. Hershkin moves for summary judgment dismissing the two causes of action asserted against him for medical malpractice and lack of informed consent. Plaintiff opposes dismissal of the medical malpractice claim, but the opposition papers are silent as to the lack of informed

consent claim.

A defendant moving for summary judgment in a medical malpractice action must make a prima facie showing of entitlement to judgment as a matter of law by showing that "in treating the plaintiff, there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged." Roques v. Nobel, 73 AD3d 204, 206 (1st Dept 2010). To satisfy the burden, defendant must present expert opinion testimony that is supported by the facts in the record, addresses the essential allegations in the complaint or the bill of particulars, and is detailed, specific and factual in nature. See id; Joyner–Pack v. Sykes, 54 AD3d 727, 729 (2nd Dept 2008). Expert opinion must be based on facts in the record or those personally known to the expert, and the opinion of defendant's expert should specify "in what way" the patient's treatment was proper and "elucidate the standard of care." Ocasio-Gary v. Lawrence Hospital, 69 AD3d 403, 404 (1st Dept 2010). Defendant's expert opinion must "explain 'what defendant did and why.'" Id (quoting Wasserman v. Carella, 307 AD2d 225, 226 [1st Dept 2003]).

"[T]o avert summary judgment, plaintiff must demonstrate that the defendant did in fact commit malpractice and that the malpractice was the proximate cause of the plaintiff's injuries." Roques v. Nobel, supra at 207. To meet this burden, "plaintiff must submit an affidavit from a medical doctor attesting that the defendant departed from accepted medical practice and that the departure was the proximate cause of the injuries alleged." Id. Where the parties' conflicting expert opinions are adequately supported by the record, summary must be denied. See Frye v. Montefiore Medical Center, 70 AD3d 15 (1st Dept 2009); Cruz v. St. Barnabas Hospital, 50 AD3d 382 (1st Dept 2008).

In support of summary judgment, Dr. Hershkin submits the expert affidavit of Dr. Raymond J. Fonseca, D.M.D. (not related to plaintiff), a Diplomate of the American Board of Oral and Maxillofacial Surgery, who reviewed the bills of particulars, the deposition transcripts, the report of Dr. Goldsmith who examined plaintiff on February 23, 2016, medical records from Dr. Hershkin and St. Luke's, and other medical records. Dr. Fonseca opines that based on plaintiff's clinical presentation, culture and sensitivity, Clindamycin was an "appropriate antibiotic" to treat her at St. Luke's, and an infectious disease consultation was not indicated when she was admitted, since she presented with a "facial plane infection and the results of her culture revealed normal respiratory flora." Dr. Fonseca also opines that osteomyelitis could not been diagnosed during plaintiff's admission at St. Luke's since it "normally takes several weeks to months" for such diagnosis. He opines that it was within the standard of care for Dr. Hershkin to discharge plaintiff on May 10, 2012, as she was "doing well post-operatively," i.e. she was "afebrile and her cell count had gone down."

Dr. Fonseca also opines was it was within the standard of care for Dr. Hershkin to perform the incision and drainage procedure on May 23, 2012, and even if the loose piece of bone had been tested, the results would have revealed "dead bone and not necessarily osteomyelitis." He opines that even if osteomyelitis had been diagnosed as a result of the May 23, 2012 procedure or after the June 12, 2012 visit, the remaining course of plaintiff's "treatment and outcome would have been the same." He opines that it was "appropriate" for Dr. Hershkin to send plaintiff for an additional CT scan on June 24, 2012, given his increased concern over her "postoperative course," and to discuss a neurosurgery consult on June 12, 2012, as the "swelling or edema were likely causing plaintiff's numbness." He opines that plaintiff's claimed injuries

could not have been caused by any negligence by Dr. Hershkin during the initial extraction procedure and subsequent care and treatment, as "osteomyelitis is a very rare infection and in plaintiff's case, it did not present in the typical fashion." Dr, Fonseca opines that a "post-operative infection is a known risk of the extraction procedure, which is noted in the written consent from and does not suggest negligence on the part of Dr. Hershkin," and he "did not see anything in the films, chart or testimony to indicate any departure from standard and accepted practice on the part of Dr. Hershkin."

Dr. Fonseca's affidavit is insufficient to satisfy Dr. Hershkin's prima facie burden on the motion, as he fails adequately to address and refute plaintiff's allegations that Dr. Hershkin departed from the standard of care by not obtaining a consultation with an infectious disease specialist both during and after plaintiff admission at St. Luke's, by discharging plaintiff on May 10, 2012, by not preserving the bone fragment during the May 23, 2012 procedure, and by not taking a biopsy or culture of the bone and test for osteomyelitis. For the most part, his opinions as to the alleged departures are conclusory and are not supported by factual details or explanations. His opinion as to causation is also stated in conclusory terms. However, even if Dr. Hershkin had made a prima facie showing, the affidavit of plaintiff's oral surgeon is sufficient to raise issues of fact as to the alleged departures and the medical malpractice claim against Dr. Hershkin.

Plaintiff's expert oral surgeon opines that pursuant to the standards of good and accepted practice, the findings of the May 7, 2012 CT scan, the ongoing infection and the finding of pus at the surgical site, "should have raised suspicion of an infection in the bone and required Dr. Hershkin" to obtain a consultation from an infectious disease specialist. The expert opines that a

"gram stain of the pus revealed many polymorphonuclear cells, gram positive cocci in pair, and gram bacilli," and the antibiotic Clindamycin does not provide "gram negative aerobic bacterial coverage, and is effective against some but not all gram negative anaerobic bacteria," which "added to the need" for an infectious disease consult. The expert opines that this departure was a substantial contributing fact to plaintiff's injuries, as an infectious disease specialist would have "ordered further testing to determine the pathogen" and would have given plaintiff the "appropriate" antibiotic that would have "effectively treated the infection." The expert notes that since neither the May 8 procedure and nor the two CT scans, showed "boney changes in the mandible" and there was no "nerve impingement at that time," if plaintiff had received effective antibiotic treatment at that time, the infection would have been "eradicated," preventing "significant or permanent damage to the mandible and any nerve injury."

Plaintiff's oral surgeon opines that Dr. Hershkin also departed from the standard of care by discharging plaintiff from St. Luke's on May 10, 2012, as the repeat CT scan taken that day showed "increases in the inflammatory process in multiple areas, as well as 'progression of obliteration of the fat planes,' and the impression was "[i]nterval progression of inflammatory changes throughout the right submandibular and parapharyngeal space in this patient who is status post recent dental extraction since 5/8/2012.'" This meant, according to plaintiff's expert, that plaintiff was "not getting better and she was not staying the same, she was getting worse," as the "inflammatory process . . . was progressing."

Plaintiff's expert opines that Dr. Hershkin further departed from the standard of care during and after the May 23, 2012 irrigation, drainage and debridement procedure, as his examination indicated "increased firm swelling over inferior of masseter with reactive edema in

neck and submandibular gland area with LAD," and loose and or missing bone on the lingual plate that "lost in suction." Plaintiff's expert opines that the presence of bone fragments was "strongly suggestive" of osteomyelitis, and required that osteomyelitis be the "presumptive diagnosis until proven otherwise" and that the loose bone fragment be "recovered, preserved and sent to pathology and evaluated for osteomyelitis and to be cultured." Objecting to Dr. Hershkin's explanation that his assistant suctioned up the loose bone before he could say anything, plaintiff's expert asserts that given Dr. Hershkin's notes that he intended to remove any necrotic bone, he should have instructed his assistant to refrain from suctioning when he was looking for such bone.

Plaintiff's expert opines that Dr. Hershkin again departed from the standard of care by failing to take a biopsy of the bone in the area of the lost fragment, and then failing to take a culture which would have "yielded significant information concerning osteomyelitis." The expert opines that the presence of the bone fragment "further increased the need" for an infectious disease consult since it was "so suggestive of osteomyelitis." The expert opines that the May 23 departures "substantially contributed" to plaintiff's injury, as if the bone fragment had been recovered and sent to pathology, or if a bone biopsy and culture had been taken, they would have revealed osteomyelitis. The expert opines that the presence of the bone fragment on May 23, indicated that the osteomyelitis had already spread to and damaged the bone, and had osteomyelitis been diagnosed at that time, "appropriate surgical intervention and intravenous antibiotic treatment would have commenced . . . [and] halted the disease process." He opines that due to the one-month delay in diagnosis and treatment, "extensive damage was done to the mandible" resulting in "significant additional injury" requiring a "much more extensive surgery"

than had the diagnosis been made shortly after the May 23, 2012 procedure.

Plaintiff's oral surgeon opines that Dr. Hershkin again departed from the standard of care when he saw plaintiff on May 30, 2012 and noted "intermittent shooting pain, total anesthesia and pins & needles right IAN distribution," and performed nerve testing showing the absence of cold and sharp sensation. Plaintiff's expert avers that those findings indicated that the "infectious process had continued to progress" and was causing "significant impairment of the inferior alveolar nerve [IAN]," which is another sign of osteomyelitis that Dr. Hershkin should have recognized. Plaintiff's expert opines that those symptoms called for a consultation with an infectious disease specialist, who would have ordered a bone biopsy. The oral surgeon opines that Dr. Hershkin again departed from the standard of care on June 12, 2012, as the "continued IAN sensory deficits were an ongoing sign of osteomyelitis," which required an infectious disease consultation. Plaintiff's expert opines that the foregoing delays in diagnosis and treatment resulted in the "disease process continuing to progress," causing additional damage to the mandible, additional injury and "more extensive repair surgery."

Plaintiff's oral surgeon addresses the opinion of Dr. Hershkin's expert, Dr. Fonseca, that an infectious disease consultation was not warranted during plaintiff's admission at St. Luke's. According to plaintiff's expert, Dr. Fonseca relied "only on the culture and ignored the gram stain result, which is inappropriate and contrary to accepted practice," and that the "finding on culture of normal respiratory flora is consistent with an oral infection." Refuting Dr. Fonseca's opinion that it was appropriate to discharge plaintiff on May 10 since she had no fever and her while cell count had gone down, plaintiff's expert opines that Dr. Fonseca "disregarded that other aspects of the blood count continued to indicate infection, as well as the fact that the while cell

count had been fluctuating up and down during admission." Plaintiff's oral surgeon opines that "most significantly," Dr. Fonseca failed to address the findings of the May 10, 2012 CT scan, showing that the "inflammatory process was progressing, getting worse." Plaintiff's expert notes that Dr. Fonseca "never mentions" the May 10 CT scan, which according to plaintiff's expert is a "critical omission because it means that Dr. Fonseca failed to consider essential information that indicated that she should remain in the hospital and that a consultation with a infectious disease specialist be obtained."

Disagreeing with Dr. Fonseca's opinion that osteomyelitis normally takes several weeks or months to diagnose, plaintiff's oral surgeon opines that diagnosis can be made "by performing a bone biopsy when the condition is present." Addressing Dr. Fonseca's opinion that testing the bone fragment would "not necessarily" have showed osteomyelitis, plaintiff's expert opines that "osteomyelitis was, with reasonable certainty, the reason for the bone damage" that was revealed during the May 23 procedure. Plaintiff's expert also disagrees with Dr. Fonseca's opinion that even if osteomyelitis had been diagnosed on May 23 or June 12, plaintiff's course and outcome would have been the same. Plaintiff's oral surgeon asserts that Dr. Fonseca "ignores" the "progression of the disease" and the "continued damage to the mandible," which affected the treatment in terms of the "degree of damage" and extent of the surgeries necessary to repair the damage, as well as plaintiff's "significant ongoing pain" during that time. Plaintiff's expert notes that Dr. Fonseca offered no opinion as to Dr. Hershkin's care on May 30, 2012, when plaintiff presented with "total anestheisa and pins and needles of the right IAN distribution and nerve testing revealed an absence of cold and sharp sensation and diminished two point discrimination along the right lower jaw," which according to plaintiff's expert "indicated a progression of the

process and was another sign of osteomyelitis."

Based on the foregoing, plaintiff has made a sufficient showing to raise issues of fact as to her medical malpractice claim against Dr. Hershkin and the alleged departures. In reply, Dr. Hershkin submits a supplemental affidavit from Dr. Fonseca, which for the most part, responds to and disagrees with the opinions of plaintiff's experts. Given these conflicting expert affidavits, summary judgment is not warranted. See Frye v. Montefiore Medical Center, supra; Cruz v. St. Barnabas Hospital, supra. Thus, Dr. Hershkin is not entitled to judgment as a matter of law dismissing the medical malpractice claim asserted against him.

Finally, Dr. Hershkin is moving for summary judgment dismissing the lack of informed consent claim and plaintiff does not oppose. A defendant moving for summary judgment on a lack of informed consent claim must make a prima facie showing that a plaintiff was informed of any foreseeable risks, benefits and alternatives of the treatment rendered. See Koi Hou Chan v. Yeung, 66 AD3d 642, 643 (2nd Dept 2009); Smith v. Cattani, 2 AD3d 259, 260 (1st Dept 2003). The mere fact plaintiff signed a consent form does not establish defendant's prima facie entitlement to judgment as a matter of law. See Godel v. Goldstein, 155 AD3d 939 (2nd Dept 2017); Santiago v. Filstein, 35 AD3d 184 (1st Dept 2006). Once defendant's burden is satisfied, plaintiff must show that defendant doctor failed to fully apprise her of the reasonably foreseeable risks, benefits and alternatives of the procedure, and a reasonable person in plaintiff's position, fully informed, would have opted against the procedure. See Orphan v. Pilnik, 15 NY3d 907, 908 (2010) (citing Public Health Law §§2805–d (1), (3)]; Eppel v. Fredericks, 203 AD2d 152 (1st Dept. 1994). "Expert medical testimony is required to prove the insufficiency of the information disclosed to the plaintiff." Orphan v. Pilnik, supra at 908; see Ramos v. Weber, 118 AD3d 408

(1st Dept 2014), lv app dism 26 NY3d 1127 (2016); Katz v. Sen, 111 AD3d 438 (1st Dept 2013).

Dr. Hershkin has made a sufficient prima facie showing that plaintiff was informed of any foreseeable risks, benefits and alternatives of the procedures he performed on April 27, May 8 and May 23, 2012. His expert, Dr. Fonseca opines that he obtained an "appropriately written consent" from plaintiff on April 27, 2012, May 8, 2012 and May 23, 2012, and it was "certainly reasonable for plaintiff to consent to these procedures." Dr. Fonseca notes that the April 27, 2012 consent form for the extractions specifically included the "risk of post-operative infection," and that all three forms state that the risks and benefits of the procedures were discussed. Dr. Fonseca points to plaintiff's testimony acknowledging that she signed each of the consent forms and that her signature was witnessed. Dr. Hershkin also testified that he discussed the risks, benefits and alternatives with plaintiff prior to each procedure. Thus, in the absence of opposition, Dr. Hershkin is entitled to judgment as a matter of law dismissing the second cause of action for lack of informed consent claim insofar as it is asserted against him.

Accordingly, it is

ORDERED that the motion for summary judgment by defendant St. Luke's-Roosevelt Hospital Center (motion seq. no. 004) is granted, and complaint in its entirety is severed and dismissed as against defendant St. Luke's -Roosevelt Hospital Center, and the Clerk is directed to enter judgment accordingly; and it is further

ORDERED that the motion for summary judgment by defendants Adam T. Hershkin, D.M.D. and Adam T. Hershkin , D.M.D., P.C. (motion seq. no. 005), is granted only to the extent that the second cause of action for lack of informed consent is severed and dismissed insofar as

asserted against said defendants, and the Clerk is directed to enter judgment accordingly; and it is further

ORDERED that the action shall continue with respect to the first cause of action for medical malpractice against defendants Adam T. Hershkin, D.M.D. and Adam T. Hershkin, D.M.D., P.C.; and it is further

ORDERED that the parties shall appear for the pre-trial conference previously scheduled for December 6, 2018 at noon, in Part 11, Room 351, 60 Centre Street.

DATED: December 3, 2018

ENTER:

J.S.C.
HON. JOAN A. MADDEN
J.S.C.